**Crossroads Services, Inc.**

**Participant Emergency Information**

In case of emergency, I give permission for treatment by emergency medical personnel, permission to transport by ambulance, and permission for emergency room treatment. I understand I will be notified of any serious illness/injury, as soon as possible.

*Name of Individual (Printed)* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Signature of Individual Date*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Parent/Guardian/Caregiver Signature (If applicable***)** *Date*

|  |  |
| --- | --- |
| **Emergency Contact Person #1 (Local)** | |
| Name |  |
| Address |  |
| Phone # 1 |  |
| Phone # 2 |  |
| Cell Phone # |  |
| Relationship |  |

|  |  |
| --- | --- |
| **Emergency Contact Person #2 (Local)** | |
| Name |  |
| Address |  |
| Phone # 1 |  |
| Phone # 2 |  |
| Cell Phone # |  |
| Relationship |  |

|  |  |
| --- | --- |
| **Emergency Contact Person #3** | |
| Name |  |
| Address |  |
| Phone # 1 |  |
| Phone # 2 |  |
| Cell Phone # |  |
| Relationship |  |

***In the event of an emergency, serious illness, or injury, Crossroads Services, Inc. will contact 911, and the closest Hospital will be utilized.***

|  |  |
| --- | --- |
| **Physician Information** | |
| Physician Name |  |
| Address |  |
| Phone # |  |

|  |  |
| --- | --- |
| **Person able to give consent for emergency medical treatment** | |
| Name |  |
| Address |  |
| Phone # 1 |  |
| Phone # 2 |  |
| Cell Phone # |  |
| Relationship |  |